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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
07487									
1. PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RURAL HOLLYWOOD					c. LENGTH OF STAY IN 1b 45 YRS.				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RURAL HOLLYWOOD 17-1				
					d. STREET ADDRESS				
3. NAME OF DECEASED (Type or print) First HOWARD Middle BENJAMIN Last ADAMS					4. DATE OF DEATH Month MAY Day 1 Year 19 66				
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH APRIL 5, 1886		9. AGE (In years last birthday) 80 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMING					10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) ST. MARY'S COUNTY, MD.	
13. FATHER'S NAME EDWIN ADAMS					12. CITIZEN OF WHAT COUNTRY? U. S. A.				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No					16. SOCIAL SECURITY NO. NONE		17. INFORMANT FRANKLIN ADAMS Address HOLLYWOOD, MARYLAND		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Atherosclerosis. DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH 6 hours				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from May 1, 1966 , to May 1, 1966 , that (I) was last saw the deceased alive on May 1, 1966 , and that death occurred at 8 A M. from the causes and on the date stated above.									
22a. SIGNATURE W.H. Patrick					22b. DATE SIGNED				
22c. PHYSICIAN'S NAME (Type) W.H. PATRICK					22d. ADDRESS Coxington PARK, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE THEREOF MAY 4, 1966		23c. NAME OF CEMETERY OR CREMATORY ST. JOHNS CEMETERY		23d. LOCATION (City, town or county) (State) HOLLYWOOD, MARYLAND		
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY ADDRESS LEONARDTOWN, MARYLAND					25a. REC'D BY REGISTRAR MAY 6 1966 DATE				
					25b. REGISTRAR'S SIGNATURE Charles Judge				

1937

1937

ST. LOUIS, MO. MAY 12, 1937

MR. J. H. HARRIS, JR., PRESIDENT, ST. LOUIS, MO.

DEAR MR. HARRIS:

I am very pleased to hear from you.

I have been thinking of you very much.

I hope you are well and happy.

I am, very truly, your friend,

Yours very truly,
J. H. HARRIS, JR.

ST. LOUIS, MO. MAY 12, 1937

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. This form is to be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY St. Mary's		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) California Pax. River		c. LENGTH OF STAY IN ID D.O.A.		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland		b. COUNTY St. Mary's		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arlington		d. STREET ADDRESS 627 N. Jackson St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) James Maurice ANDERSON Jr.		4. DATE OF DEATH Month May Day 14 Year 1966		5. SEX Male		6. COLOR OR RACE Cauc		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 14 April 1942		9. AGE (In years last birthday) 24 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LT(jr)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LT(jr)		10b. KIND OF BUSINESS OR INDUSTRY USNR		11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME James Maurice ANDERSON		14. MOTHER'S MAIDEN NAME ELISABETH HANSEL		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 4-10-63 to 224-54-3516	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 4-10-63 to 224-54-3516		17. INFORMANT Military Records		18. CAUSE OF DEATH (Enter brief description per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Injuries, MULTIPLE, EXTREME DUE TO (b) Automobile Accident DUE TO (c) Automobile Accident		INTERVAL BETWEEN ONSET AND DEATH Immediate		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. Automobile Accident		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Automobile Accident	
20c. TIME OF INJURY Month, Day, Year May 14 1966		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Mill Cove Road		20f. (City or town) California		(County) St. Mary's		(State) Md.		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		22. DATE SIGNED 14 May 1966	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		22. DATE SIGNED 14 May 1966		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-19-1966		23c. NAME OF CEMETERY OR CREMATORY Arlington Natl Cem		23d. LOCATION (City, town or county) 7th Meyer Va.		24. FUNERAL DIRECTOR W.W. Chambers Co		25a. REC'D BY REGISTRAR Charles Judge	
24. FUNERAL DIRECTOR W.W. Chambers Co		25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge		25c. ADDRESS 3072 1st St NW, Wash. D.C.		25d. DATE MAY 23 1966		25e. ADDRESS (Street, city, town, or county) NAS PAX RIV MD		25f. DATE MAY 23 1966			

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THE UNIVERSITY OF CHICAGO

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THE UNIVERSITY OF CHICAGO

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE HEALTH DEPT.

07488

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07483

1. PLACE OF DEATH a. COUNTY <u>St. Mary's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>St. Mary's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Abell Rural</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Abell</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>Lawrence</u> Middle <u>Fales</u> Last <u>Ayers</u>				4. DATE OF DEATH Month <u>May</u> Day <u>21</u> Year <u>66</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 2, 1910</u>		9. AGE (In years last birthday) <u>55</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Operator (Retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>D.C. Transit</u>		11. BIRTHPLACE (State or foreign country) <u>New York N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Harry XXXX Ayers</u>				14. MOTHER'S MAIDEN NAME <u>? Laurie Fales</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>578-10-7570</u>		17. INFORMANT <u>Mrs Lawrence F. Ayers</u>		Address <u>Same as # 2 above</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201</u> DUE TO <u>Coronary Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: } (b) _____ DUE TO _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>assumed</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>William D. Boyd M.D.</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>William D. Boyd M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>May 24, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Stonewall Memory Gardens</u>		23d. LOCATION (City or Town) (County) (State) <u>Manassas, Virginia</u>	
24. FUNERAL DIRECTOR <u>Everly-Whetley</u>				25a. REC'D BY REGISTRAR <u>MAY 24 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY St. Mary's b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Leonardtwn c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) St. Mary's Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Charles c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bryantown d. STREET ADDRESS Rural e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First Donna Middle Lorraine Last Buckler					4. DATE OF DEATH Month May Day 29 Year 19 66						
5. SEX Female					6. COLOR OR RACE White						
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH May 28 1966						
9. AGE (In years last birthday) 1					10. IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min.						
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none					11b. KIND OF BUSINESS OR INDUSTRY -----						
12. BIRTHPLACE (County & State, or foreign country) St. Marys Co., Maryland					13. CITIZEN OF WHAT COUNTRY? USA						
14. FATHER'S NAME James Martin Buckler					15. MOTHER'S MAIDEN NAME Erma Jane Raley						
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)					17. SOCIAL SECURITY NO. -----						
18. INFORMANT Mother					19. Address Bryantown, Maryland						
20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 7625 Pulmonary Atelectasis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pneumothorax DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										INTERVAL BETWEEN ONSET AND DEATH	
21. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										22. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
23a. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.					24. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					25. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
26. (City or town) Mechanicsville, Maryland					27. (County) Charlotte Hall, Maryland					28. (State)	
29. I certify that (I) (this hospital) attended the deceased from 19 , to 19 , that (I) (we) last saw the deceased alive on 19 , and that death occurred at M , from the causes and on the date stated above.										30. DATE SIGNED 5/30/66	
31. SIGNATURE William C. Mulford					32. M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					33. ADDRESS Mechanicsville, Maryland	
34. PHYSICIAN'S NAME (Type) William C. Mulford					35. DATE JUN 6 1966					36. REGISTRAR'S SIGNATURE Charles Judge	
37. BURIAL, CREMATION, REMOVAL (Specify) Burial					38. DATE THEREOF 6/2/66					39. NAME OF CEMETERY OR CREMATORY All Faith Cemetery	
40. FUNERAL DIRECTOR P.B. Robinson					41. ADDRESS Leonardtwn, Md.					42. DATE JUN 6 1966	

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VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
07491					07485						
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)						
a. COUNTY St. Marys					a. STATE MD						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown					b. COUNTY CALVERT						
c. LENGTH OF STAY IN 1b 7 M.O.					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SOLOMONS						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Marys Hospital					d. STREET ADDRESS —						
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print)			First		Middle		Last		4. DATE OF DEATH		
			MARY		ANN		DeBOY		Month May		
									Day 29		
									Year 19 66		
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 23, 1887		9. AGE (in years last birthday) 78 yrs.		10. IF UNDER 1 YEAR Months — Days — Hours — Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Domestic				11. BIRTHPLACE (County & State, or foreign country) BALTIMORE MD		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert J. Wheeler (dec)					14. MOTHER'S MAIDEN NAME Dora J. Condon (dec)						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO					16. SOCIAL SECURITY NO. 220-46-7026					17. INFORMANT Frank P. DeBoy	
					Address SOLOMONS, MD.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Circulatory Collapse 1538 DUE TO (b) Carcinomatosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Adenocarcinoma of Colon										WHO.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 6 , 19 65 , to 5/29 , 19 66 , that (I) (we) last saw the deceased alive on 5/29/66 , and that death occurred at 1235 A.M. from the causes and on the date stated above.											
22a. SIGNATURE James P. Jarboe					M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5/29/66		
22c. PHYSICIAN'S NAME (Type) Jos. P. Jarboe, M.D.					22d. ADDRESS Great Mills, Maryland						
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF 6/2/66		23c. NAME OF CEMETERY OR CREMATORY LOUPON PARK CEM.			23d. LOCATION (City, town or county) (State) BALTIMORE MD			
24. FUNERAL DIRECTOR A. A. Harkness & Son					ADDRESS Mathias Bldg 34		25a. REC'D BY REGISTRAR JUN 1 1966		25b. REGISTRAR'S SIGNATURE Charles Judge		

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed with in 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pen on page 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM3. Page 5 may be retained for your files.

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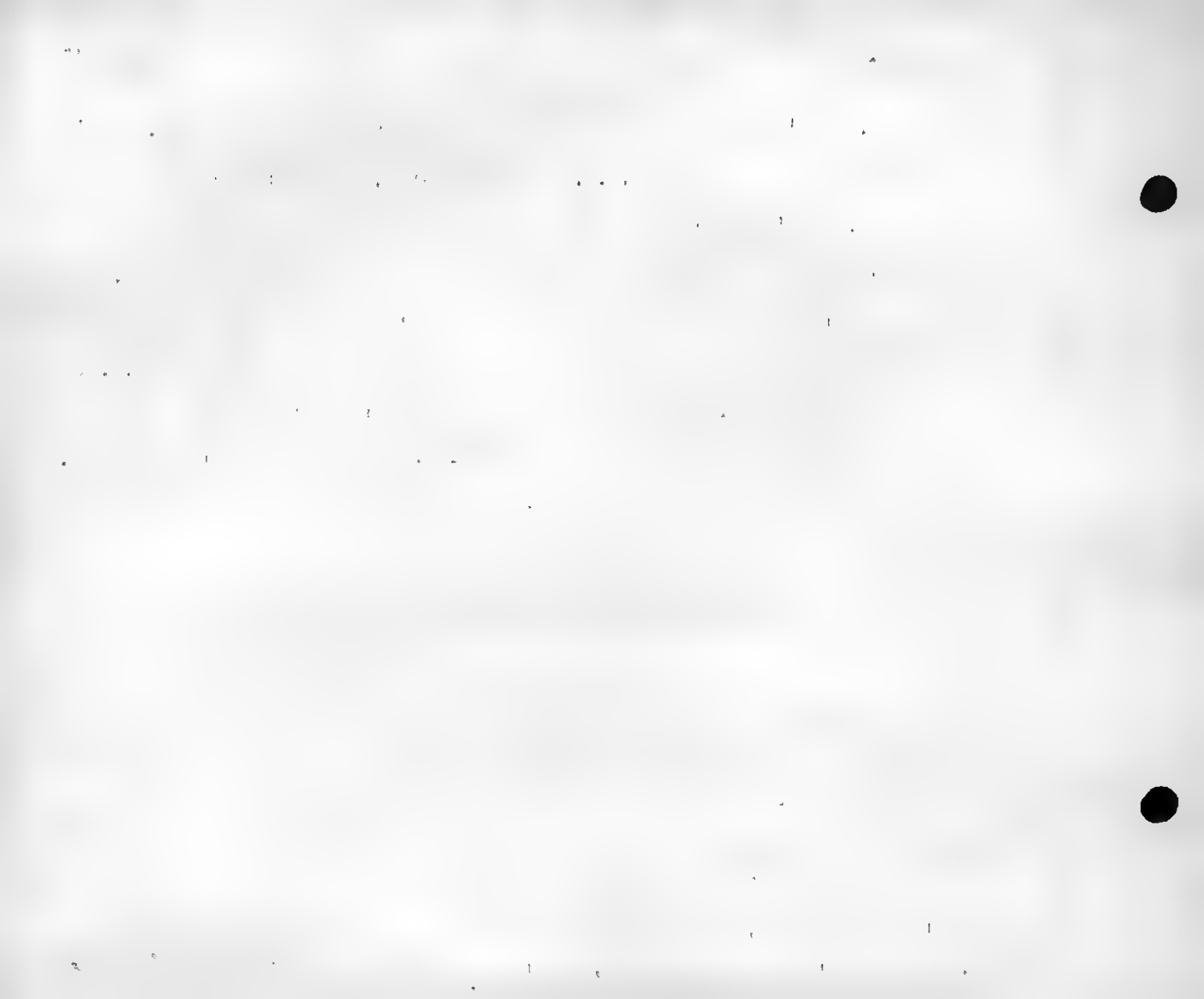
MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH						07486					
1 PLACE OF DEATH a. COUNTY St. Mary's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown c. LENGTH OF STAY IN 1b 1 hour d. NAME OF HOSPITAL OR INSTITUTION (If not a hospital, give street address) St. Mary's Hospital						2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bushwood d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3 NAME OF DECEASED (Type or print) First Middle Last THOMAS XXXXX HARRY XXXXX DRURY						4 DATE OF DEATH Month Day Year May 5 1966					
5 SEX Male		6 COLOR OR RACE White		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH DEC. 14, 1911		9 AGE (n years last birthday) 54 y/s		10 UNDER 1 YEAR Months Days 5 1966	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER				10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) MARYLAND			12 CITIZEN OF WHAT COUNTRY? U.S.A.		
13 FATHER'S NAME PHILIP C. DRURY						14 MOTHER'S MAIDEN NAME MARY LUCINDA BAILEY					
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16 SOCIAL SECURITY NO 577-16-6489		17 INFORMANT Address MARY B. DRURY BUSHWOOD, MARYLAND					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY 976x IMMEDIATE CAUSE (a) Contact gunshot wound of left chest DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____ DUE TO (c) _____											
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Shot self with shotgun in left chest							
20c. TIME OF INJURY Month, Day, Year Hour a.m. xx 5/5 86				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Bushwood, St. Mary's Md.			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Rudiger Breiteneker, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) 5/5/66							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF MAY 9, 1966		23c. NAME OF CEMETERY OR CREMATORY SACRED HEART CHURCH CEM.				23d. LOCATION (City or Town) (County) (State) BUSHWOOD, MARYLAND			
24. FUNERAL DIRECTOR ADDRESS W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND						25a. REC'D BY REGISTRAR DATE MAY 10 1966		25b. REGISTRAR'S SIGNATURE Charles Judge			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07493		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		07487	
1 PLACE OF DEATH a. COUNTY ST. MARY'S			2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN			b. COUNTY ST. MARY'S		
c. LENGTH OF STAY IN Id D.O.A.			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ORVILLE, MECHANICSVILLE		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ST. MARY'S HOSPITAL			d. STREET ADDRESS e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) MICHAEL ANTHONY			4. DATE OF DEATH Month MAY Day 3 Year 1966		
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH APRIL 8, 1961		9. AGE (In years last birthday) 5 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME DARRELL E. ERSKINE		14. MOTHER'S MAIDEN NAME MARGIE MARIE BALDWIN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT DARRELL E. ERSKINE Address MECHANICSVILLE, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Multiple Injuries (Severe) 8124 DUE TO (b) Fractures of both femurs and left arm DUE TO (c) Laceration rt. side scalp-puncture wound left skull - internal injuries			INTERVAL BETWEEN ONSET AND DEATH Instant		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Child struck while crossing Highway 235			
20c. TIME OF INJURY Month Day Year Hour 7:52 p.m. 5/3 19 66		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway 235	
20f. (City or town) Orville		20g. (County) St. Mary's		20h. (State) Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE W.H. Patrick		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 5-4-66	
EXAMINER'S NAME (Type) W.H. PATRICK M.D. ASS		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county)					
23a. BURIAL, CREMATION REMOVAL (Specify) BURIAL		23b. DATE THEREOF MAY 6, 1966		23c. NAME OF CEMETERY OR CREMATORY MT ZION CEMETERY	
23d. LOCATION (City or Town) LAUREL GROVE, MARYLAND		23e. REG'D BY REGISTRAR MAY 6 1966		23f. REGISTRAR'S SIGNATURE Charles Judge	
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND					

VR AISME (5)
6M 1/66



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
CERTIFICATE OF DEATH														
1. PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) LEONARDTOWN					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) LEONARDTOWN									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) ST. MARY'S HOSPITAL					d. STREET ADDRESS 18-1									
3. NAME OF DECEASED (Type or print) First CHARLES Middle BENEDICT Last GREENWELL					4. DATE OF DEATH Month MAY Day 12 Year 1966									
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JAN. 10, 1898		9. AGE (In years last birthday) 68 yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK OF THE COURT				10b. KIND OF BUSINESS OR INDUSTRY ST. MARY'S COUNTY		11. BIRTHPLACE (County & State, or foreign country) MEDLEY'S NECK, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.						
13. FATHER'S NAME CHARLES BENEDICT GREENWELL					14. MOTHER'S MAIDEN NAME ANNA ABELL									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES (If yes give war or dates of service) WW I					16. SOCIAL SECURITY NO. WW I					17. INFORMANT FLORENCE D. GREENWELL Address SAME AS # 2 ABOVE				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ruptured Aortic Aneurysm DUE TO (b) Arteriosclerosis DUE TO (c) 107 years CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last, 107 years										INTERVAL BETWEEN ONSET AND DEATH 1 hour				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				
20f. (City or town) (County) (State)														
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.														
22a. SIGNATURE John F. Fenwick					22b. DATE SIGNED 5-16-66									
22c. PHYSICIAN'S NAME (Type) JOHN F. FENWICK M. D.					22d. ADDRESS LEONARDTOWN, MARYLAND									
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL					23b. DATE THEREOF MAY 14, 1966					23c. NAME OF CEMETERY OR CREMATORY OUR LADY'S CHAPEL				
23d. LOCATION (City, town or county) (State) MEDLEY'S NECK, MARYLAND														
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY					ADDRESS LEONARDTOWN, MARYLAND					25a. REC'D BY REGISTRAR MAY 17 1966				
										25b. REGISTRAR'S SIGNATURE Charles Judge				

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

<div> <div>1</div> <div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>074895</div> </div> <div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>07489</div> </div> </div>									
1. PLACE OF DEATH a. COUNTY St. Marys MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtwn c. LENGTH OF STAY IN 1b DOA d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Marys Hospital					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY St. Marys c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) St. Clement's Shores (Leonardtwn) d. STREET ADDRESS Rt.#2 Box 67 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First BERNARD Middle FRANK Last HEARD, Sr.			4. DATE OF DEATH Month May Day 7 Year 1966		5. SEX male 6. COLOR OR RACE white 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 9/16/1894 9. AGE (In years last birthday) 71 yrs.			10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Police 10b. KIND OF BUSINESS OR INDUSTRY D.C. Police Dept. 11. BIRTHPLACE (State or foreign country) Leonardtwn, Maryland 12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James A. Heard (dec) 14. MOTHER'S MAIDEN NAME Susan Pope (dec)				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) y (If yes give war or dates of service) WW1 16. SOCIAL SECURITY NO. 220 44 2449 17. INFORMANT Sadie G. Heard - same as # 2		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 4201 (c) 4201 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) None		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE WH Patrick M.D.		EXAMINER'S NAME (Type) WH PATRICK M.D.		22. DATE SIGNED 5/8/66		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 5/10/66 23c. NAME OF CEMETERY OR CREMATORY ST. Paul's Cemetery 23d. LOCATION (City, town or county) Leonardtwn, Maryland			
24. FUNERAL DIRECTOR P.B. Robinson 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE Charles Judge		DATE MAY 10 1966							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

VR A15 (4)
15M 4-64

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY St. Marys MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY St. Marys					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) St. George's Island					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Marys Nurseing Home						d. STREET ADDRESS Rural				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) SADIE			First MARIA			Middle HENDERSON			Last		
4. DATE OF DEATH May 5			Month May			Day 5			Year 1966		
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/24/1875		9. AGE (In years last birthday) 90 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Domestic				11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph F. Robrecht (dec)						14. MOTHER'S MAIDEN NAME Anna Twilley (dec)					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) no				16. SOCIAL SECURITY NO. N/A		17. INFORMANT Lawrence Henderson - same as #2					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Arteriosclerotic cardiovascular disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pneumonia - left lower lobe										INTERVAL BETWEEN ONSET AND DEATH 1 hr 16 yrs	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from May 4, 1966 , to May 5, 1966 , that (I) (we) last saw the deceased alive on May 4, 1966 , and that death occurred at 2:30 A.M. from the causes and on the date stated above.											
22a. SIGNATURE J. Roy Guyther						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5/5/66			
22c. PHYSICIAN'S NAME (Type) J. Roy Guyther, M.D.						22d. ADDRESS Mechanicsville, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 5/7/66		23c. NAME OF CEMETERY OR CREMATORY Wesley Chapel Cemetery		23d. LOCATION (City, town or county) (State) Rock Hall, Maryland			
24. FUNERAL DIRECTOR P.B. Robinson						ADDRESS P.B. Robinson - Leonardtown, Maryland		25a. REC'D BY REGISTRAR MAY 9 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please send the carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY St. Marys MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY St. Marys				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtwn					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mechanicsville				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Marys Hospital					d. STREET ADDRESS Mechanicsville				
3. NAME OF DECEASED (Type or print) First CHARLES Middle PAUL Last HERBERT					4. DATE OF DEATH Month May Day 9 Year 19 66				
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 18, 1870		9. AGE (In years last birthday) 95 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Merchant		10b. KIND OF BUSINESS OR INDUSTRY General Store		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13. FATHER'S NAME George W. Herbert (dec)					14. MOTHER'S MAIDEN NAME Susan Higgs (dec)				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no					16. SOCIAL SECURITY NO. N/A		17. INFORMANT Mrs. Eliza Davis - same as # 2		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Arteriosclerosis 4201 DUE TO (b) arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Aneurysm INTERVAL BETWEEN ONSET AND DEATH intermittent soon					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from Oct 57, 1957 to May 1966 , that (I) (we) last saw the deceased alive on 9 May 1966 , and that death occurred at M , from the causes and on the date stated above.									
22a. SIGNATURE David L. Mossmon					22b. DATE SIGNED 5/9/66				
22c. PHYSICIAN'S NAME (Type) David L. Mossmon M.D. J. Roy Guyther, M.D.					22d. ADDRESS Mechanicsville, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 5/12/66		23c. NAME OF CEMETERY OR CREMATORY All Faith Cemetery		23d. LOCATION (City, town or county) (State) Charlotte Hall, Maryland		
24. FUNERAL DIRECTOR P.B. Robinson					25a. REC'D BY REGISTRAR MAY 13 1966				
25b. REGISTRAR'S SIGNATURE Charles Judge									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="display: flex; justify-content: space-between;"> <div> <p>5</p> <p>1</p> </div> <div> <p>MARYLAND STATE DEPARTMENT OF HEALTH</p> <p>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</p> <p>CERTIFICATE OF DEATH</p> </div> <div> <p>07498</p> <p>07492</p> </div> </div>										
1. PLACE OF DEATH a. COUNTY St. Marys MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY St. Marys					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clements			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clements					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rural					d. STREET ADDRESS Rural			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First AGNES Middle M. Last HURRY					4. DATE OF DEATH Month May Day 18 Year 19 66					
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 1, 1887		9. AGE (In years last birthday) 78 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY domestic		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME William Raley					14. MOTHER'S MAIDEN NAME Elizabeth Cecil					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. ---		17. INFORMANT John W. Hurry - same as # 2				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure. 443X DUE TO (b) Chronic Myocarditis + Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____									INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____				
21. I certify that (I) (this hospital) attended the deceased from 5/11 , 19 66 to 5/18 , 19 66 that (I) (we) last saw the deceased alive on 5/18 , 19 66 , and that death occurred at 6 P.M. from the causes and on the date stated above.										
22a. SIGNATURE Charles Greenwell M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5/18/66			
22c. PHYSICIAN'S NAME (Type) Charles Greenwell, M.D.					22d. ADDRESS Leonardtown, Maryland					
23a. BURIAL, CREMATION, REMOVAL (S <input type="checkbox"/> if Y)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) _____ (State) _____				
Burial		5/21/66		St. Joseph Cemetery		Morganza, Maryland				
24. FUNERAL DIRECTOR P.B. Robinson					ADDRESS P.B. Robinson - Leonardtown, Maryland		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE Charles Judge	
					DATE MAY 23 1966					

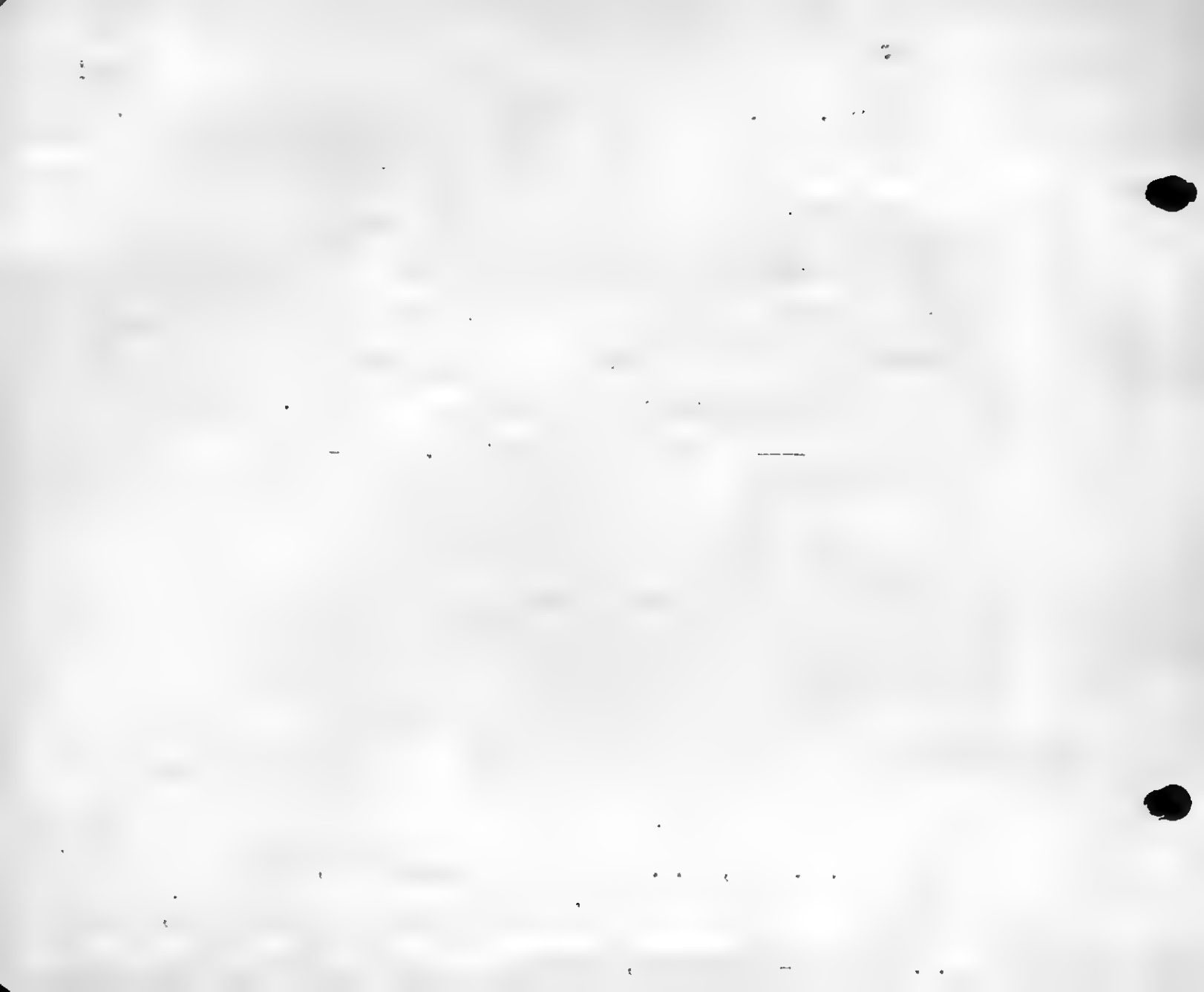
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
3500 4-64

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH </div>									
1. PLACE OF DEATH a. COUNTY St. Marys MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Valley Lee c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) HERRING CREEK					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY St. Marys c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown d. STREET ADDRESS RFD Rural e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First RICHARD Middle BENEDICT Last MAYOR					4. DATE OF DEATH Month May Day 28 Year 19 66				
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/23/1931		9. AGE (In years last birthday) 34 yrs. IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____ IF UNDER 24 HRS.: _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic				10b. KIND OF BUSINESS OR INDUSTRY US Navy		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph Leonard Mayor					14. MOTHER'S MAIDEN NAME Myrtle E. Ridgell				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 212 30 3904		17. INFORMANT Regina E. Mayor - same as # 2			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 2 (c)									INTERVAL BETWEEN ONSET AND DEATH assumed
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell from row boat unnoticed					
20c. TIME OF INJURY Month, Day, Year Hour 5:00 p.m. 5-28 19 66				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Herring Creek		20f. (City or town) (County) (State) Valley Lee St Marys Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE Wm. D. Boyd, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22. DATE SIGNED 5/28/66		
EXAMINER'S NAME (Type) Wm. D. Boyd, M.D.				Leonardtown, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/31/66		23c. NAME OF CEMETERY OR CREMATORY Holy Face Cemetery		23d. LOCATION (City, town or county) (State) Great Mills, Maryland			
24. FUNERAL DIRECTOR P.B. Robinson - Leonardtown, Maryland				ADDRESS		25a. REC'D BY REGISTRAR JUN 6 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	



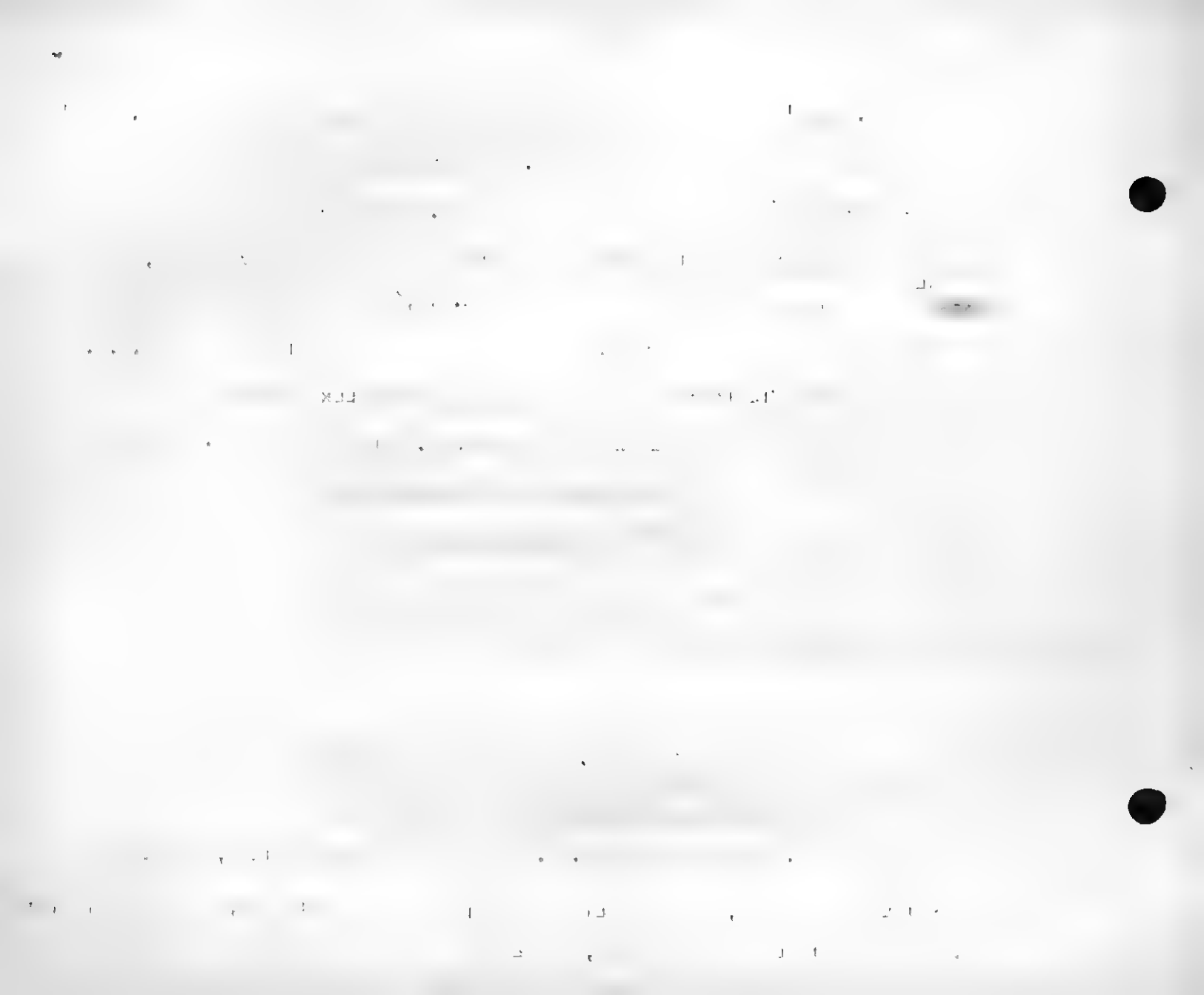
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HOLLYWOOD				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HOLLYWOOD			
c. LENGTH OF STAY IN 1b 10 YRS.				d. STREET ADDRESS Rt. 1 Box 206 A			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Rt 1 Box 206 A				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JEAN Middle WILLIAMSON Last NALLEY				4. DATE OF DEATH Month MAY Day 12 Year 19 66			
5. SEX FEMALE		6. COLOR OR RACE CAUCASIAN		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH FEB. 12, 1907	
9. AGE (In years last birthday) 59 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TEACHER		10b. KIND OF BUSINESS OR INDUSTRY SCHOOL		11. BIRTHPLACE (County & State, or foreign country) ARIZONA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JOHN WILLIAMSON		14. MOTHER'S MAIDEN NAME ANNABELLE NORTON			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 213-38-2580		17. INFORMANT JOSEPH C. NALLEY SAME AS # 2 ABOVE			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 170X Carcinomatosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Plenocarcinoma of Breast DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 6 mo	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1/7, 1966 to 5/12, 1966 , that (I) (we) last saw the deceased alive on 29/12, 1966 and that death occurred at 5 PM , from the causes and on the date stated above.							
22a. SIGNATURE J. Patrick Jarboe				22b. DATE SIGNED MAY 17 1966		22c. PHYSICIAN'S NAME (Type) J. PATRICK JARBOE M. D.	
22d. ADDRESS GREAT MILLS, MARYLAND							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF MAY 16, 1966		23c. NAME OF GEMETERY OR GREMATORY ARLINGTON NATIONAL		23d. LOCATION (City, town or county) (State) ARLINGTON, VIRGINIA	
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND				25a. REC'D BY REGISTRAR MAY 17 1966			
				25b. REGISTRAR'S SIGNATURE J. Charles Judge			



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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>St Mary's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>St. Mary's</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Great Mills</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Great Mills</u>	
c. LENGTH OF STAY IN 1b <u>Life</u>		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>John V. ...</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>VIVIAN</u> Last <u>NORRIS</u>		4. DATE OF DEATH Month <u>May</u> Day <u>6</u> Year <u>1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Dec 5, 1904</u>
9. AGE (In years) <u>61</u> yrs. IF UNDER 1 YEAR: Months <u>61</u> Days <u>61</u> Hours <u>61</u> Min. <u>61</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTH PLACE (County & State, or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Warren Norris</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Catherine Stone</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-28-5718</u>	
17. INFORMANT <u>Jenifer Norris</u>		Address <u>Great Mills, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular Fibrillation</u> DUE TO (b) <u>Myocardial Infarction</u> DUE TO (c) <u>4201</u>		INTERVAL BETWEEN ONSET AND DEATH <u>min</u> <u>min</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <u>5/6</u> to <u>5/6</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>5/6</u> , 19 <u>66</u> , and that death occurred at <u>1:45</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>James O. Clarke</u>		22b. DATE SIGNED <u>5/7/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>James O. Clarke</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5-9-66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Holy Face</u>		23d. LOCATION (City, town or county) (State) <u>Great Mills Md.</u>	
24. FUNERAL DIRECTOR <u>W. Clarke Mattingley</u>		25a. REC'D BY REGISTRAR <u>May 10 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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VR A15 (4)
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ST. GEORGE ISLAND			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) ST. MARY'S HOSPITAL				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First EDGAR Middle LEWIS Last PEARSON				4. DATE OF DEATH Month MAY Day 3 Year 1966			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JULY 26, 1882	
9. AGE (In years last birthday) 83 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WATERMAN		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) U. S. A.	
13. FATHER'S NAME GEORGE T. PEARSON				14. MOTHER'S MAIDEN NAME EMMA JANE BRAMBLE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. 220-32-6214			
17. INFORMANT H. RALPH PEARSON				Address 232 ARAPAHOE DRIVE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) pulmonary embolism 1500 DUE TO phlebotrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerosis, generalized DUE TO (c)				FOREST HEIGHTS, MD. INTERVAL BETWEEN ONSET AND DEATH 10 min. ?			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.							
22a. SIGNATURE John F. Fenwick				22b. DATE SIGNED 5-5-66			
22c. PHYSICIAN'S NAME (Type) JOHN F. FENWICK XXXXXX M. D.				22d. ADDRESS LEONARDTOWN, MARYLAND XXXXXXXXXXXXXXXXXXXX			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF MAY 6, 1966		23c. NAME OF CEMETERY OR CREMATORY ST. GEORGE ISLAND M.E.		23d. LOCATION (City, town or county) (State) ST. GEORGE ISLAND, MARYLAND	
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY				ADDRESS LEONARDTOWN, MARYLAND		25a. REC'D BY REGISTRAR MAY 6 1966	
				25b. REGISTRAR'S SIGNATURE Charles Judge			

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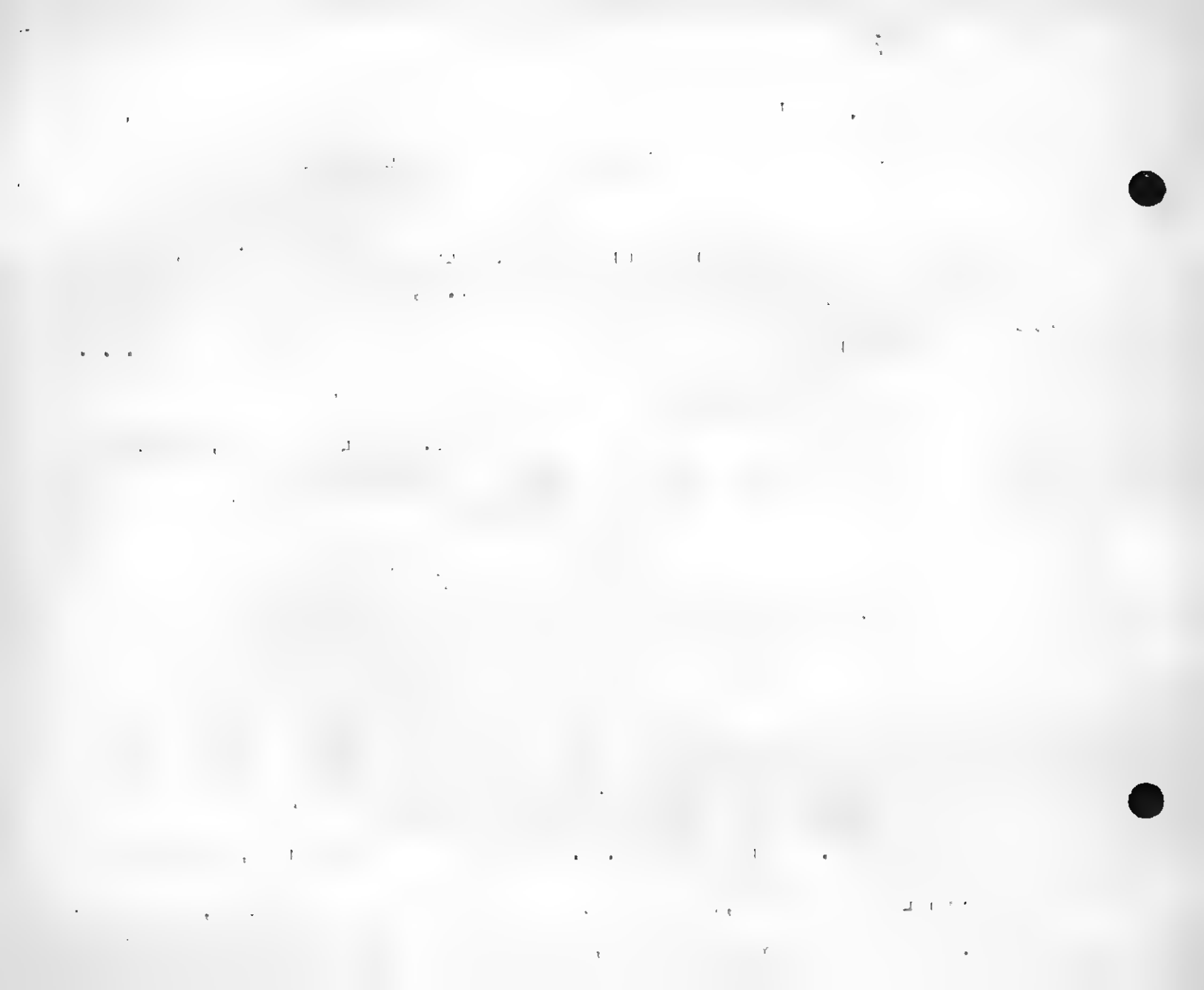
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MARYLAND STATE DEPARTMENT OF HEALTH																			
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																			
CERTIFICATE OF DEATH																			
07503 07497																			
1. PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S														
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) PARK HALL					c. LENGTH OF STAY IN 1b 6 MONTHS					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RURAL SCOTLAND									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					d. STREET ADDRESS					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Middle Last CATHERINE ELIZABETH PURNELL					4. DATE OF DEATH Month Day Year MAY 6, 1966														
5. SEX FEMALE		6. COLOR OR RACE COLORED		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH SEPT. 28, 1886		9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE					10b. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (County & State, or foreign country) MARYLAND					12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME CHARLES BUTLER					14. MOTHER'S MAIDEN NAME ISABELL BUTLER														
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>					16. SOCIAL SECURITY NO. (If yes give war or dates of service)					17. INFORMANT GEORGE S. PURNELL					Address SCOTLAND, MARYLAND				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Collapse 715X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Sepsis (c) Pressure ulcers PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Antenatal C-V Disease										INTERVAL BETWEEN ONSET AND DEATH hr, day, wk									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Rem 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that (I) (the hospital) attended the deceased from 11/1, 1965 to 5/6, 1966 , that (I) (the hospital) last saw the deceased alive on 5/6, 1966 , and that death occurred at 8:30 AM , from the causes and on the date stated above.										22a. SIGNATURE J. Partick Jarboe M. D.					22b. DATE SIGNED				
22c. PHYSICIAN'S NAME (Type) J. PARTICK JARBOE M. D.					22d. ADDRESS GREAT MILLS, MARYLAND														
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL					23b. DATE THEREOF MAY 10, 1966					23c. NAME OF CEMETERY OR CREMATORY ST. LUKES CEMETERY					23d. LOCATION (City, town or county) (State) SCOTLAND MARYLAND				
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY					ADDRESS LEONARDTOWN, MARYLAND					25a. REC'D BY REGISTRAR DATE MAY 10 1966					25b. REGISTRAR'S SIGNATURE J. Charles Judge				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
CERTIFICATE OF DEATH										
1. PLACE OF DEATH a. COUNTY St. Marys MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Tennessee b. COUNTY Shelby					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtwn			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Memphis					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) St. Marys Hospital					d. STREET ADDRESS 1508- Madison Ave.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First JOHN Middle EDMUND Last RICHARDS					4. DATE OF DEATH Month May Day 26 Year 19 66					
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/8/1925		9. AGE (in years last birthday) 40 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman				10b. KIND OF BUSINESS OR INDUSTRY Mobile Homes		11. BIRTHPLACE (County & State, or foreign country) Memphis, Tennessee		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME James Walter Richards (dec)					14. MOTHER'S MAIDEN NAME Catherine Matte					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give war or dates of service) WW 2				16. SOCIAL SECURITY NO.		17. INFORMANT Catherine M. Richards - same as # 2				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ischemic Encephalopathy 5811 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Laennec's Cirrhosis DUE TO (c) _____								INTERVAL BETWEEN ONSET AND DEATH 2 weeks 2-4 years		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 19 to 26 May, 1966 , that (I) (we) last saw the deceased alive on 26 May 1966 , and that death occurred at 1:30 p.m. from the causes and on the date stated above.										
22a. SIGNATURE Ernest M. Rehm					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5/26/66			
22c. PHYSICIAN'S NAME (Type) Ernest Rehm, M.D.					22d. ADDRESS Lexington Park, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/30/66		23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery			23d. LOCATION (City, town or county) (State) Memphis, Tennessee			
24. FUNERAL DIRECTOR P.B. Robinson					ADDRESS P.B. Robinson - Leonardtown, Maryland		25a. REC'D BY REGISTRAR MAY 31 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

MEDICAL CERTIFICATION

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

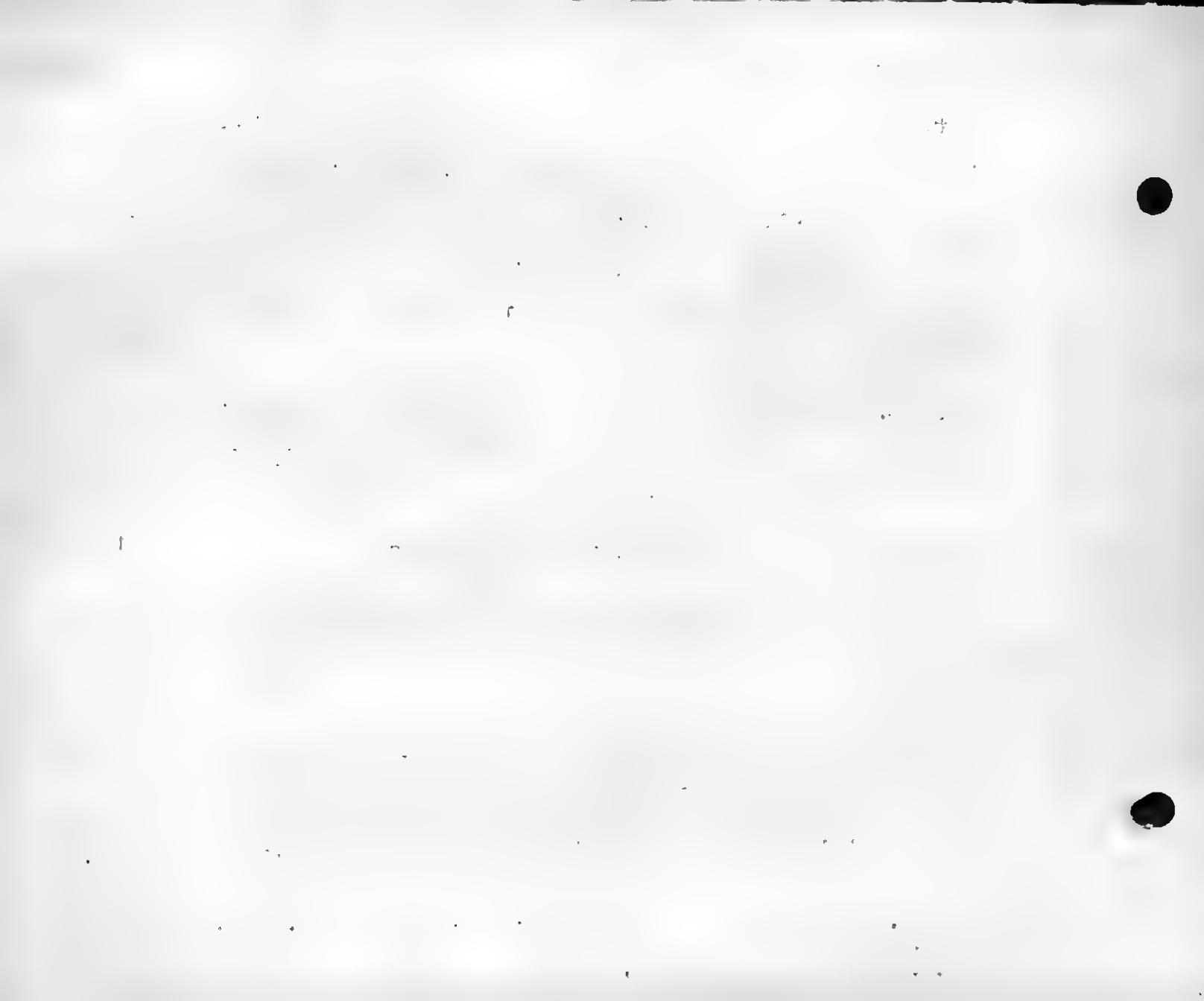
VR A15ME (5)
5M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

37505

08946

1. PLACE OF DEATH a. COUNTY St. Marys b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lexington Park c. LENGTH OF STAY IN 1b Two(2) months d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Station Hospital, NAS, PAXRIVMD		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY St. Marys c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lexington, Park d. STREET ADDRESS Lot #5, National Trailer Pk e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Patricia Ann ROBINSON		4. DATE OF DEATH Month Day Year May 29 1966	
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 14 Feb 1945
9. AGE (In years last birthday) 21 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Minnesota		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Fred L. DURDIN		14. MOTHER'S MAIDEN NAME Everetta M. WICHMAN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT James W. ROBINSON (Husband) same as number two (2) above		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congenital Heart Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
INTERVAL BETWEEN ONSET AND DEATH 21 years			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE J. P. CLOHERTY LT MC USN		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Wm Boyd MD		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED 5/31/66		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 5/31/66	23c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery	23d. LOCATION (City, town or county) (State) St. Paul, Minnesota
24. FUNERAL DIRECTOR P.B. Robinson		25a. REC'D BY REGISTRAR JUN 6 1966	
Address P.B. Robinson - Leonardtown, Maryland		25b. REGISTRAR'S SIGNATURE J. Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. *Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.*

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
07506 08947									
1. PLACE OF DEATH a. COUNTY ST. MARYS MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARYS				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First PIUS Middle BENEDICT Last ROBINSON					4. DATE OF DEATH Month MAY Day 31 Year 1966				
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH OCT. 11, 1915		9. AGE (in years last birthday) 50 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FUNERAL DIRECTOR				10b. KIND OF BUSINESS OR INDUSTRY FUNERAL		11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ERNEST L. ROBINSON					14. MOTHER'S MAIDEN NAME ANNIE MAY RIDGELL				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 578 01 9579		17. INFORMANT ELLEN H. ROBINSON			Address SAME AS #2		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular fibrillation 4201 DUE TO (b) Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Coronary Atherosclerosis								INTERVAL BETWEEN ONSET AND DEATH minutes minutes 4 yr	
								PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Oct , 19 57 to May , 19 66 that (I) (we) last saw the deceased alive on May , 19 66 , and that death occurred at 4:47 A.M., from the causes and on the date stated above.									
22a. SIGNATURE David L. Mossman				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 6/2/66			
22c. PHYSICIAN'S NAME (Type) DAVID L. MOSSMAN M.D.				22d. ADDRESS MECHANICSVILLE, MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 6/3/66		23c. NAME OF CEMETERY OR CREMATORY ST. ALOYSIUS CEM.		23d. LOCATION (City, town or county) (State) LEONARDTOWN, MARYLAND			
24. FUNERAL DIRECTOR John M. Welch				ADDRESS JOHN M. WELCH - LEONARDTOWN, MARYLAND		25a. REC'D BY REGISTRAR JUN 7 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. CDUNTY ST. MARY'S b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN c. LENGTH OF STAY IN 1b 1 DAY d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) ST. MARY'S HOSPITAL					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. CDUNTY ST. MARY'S c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL GREAT MILLS d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First CECIL Middle GEROME Last STRICKLAND			4. DATE OF DEATH Month MAY Day 2 Year 19 66						
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH OCT. 24, 1909		9. AGE (In years last birthday) 56 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMING				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) NORTH CAROLINE		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CYRUS M. STRICKLAND					14. MOTHER'S MAIDEN NAME HELEN FRANCIS TAYLOR				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO. 216-18-5361		17. INFORMANT MRS HELEN G. STRICKLAND GREAT MILLS, MARYLAND		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Head of Pancreas 157X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. With Generalized Metastasis DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH 6 mos.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from OCT , 19 65 , to MAY 2 , 19 66 that (I) (we) last saw the deceased alive on MAY 2 , 19 66 , and that death occurred at 8:45 AM, from the causes and on the date stated above.									
22a. SIGNATURE W.H. Patrick					22b. DATE SIGNED				
22c. PHYSICIAN'S NAME (Type) W.H. PATRICK					22d. ADDRESS LEXINGTON PARK Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF MAY 4, 1966		23c. NAME OF CEMETERY OR CREMATORY EBENEZER CEMETERY		23d. LOCATION (City, town or county) (State) GREAT MILLS, MARYLAND			
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND					25a. REC'D BY REGISTRAR MAY 6 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge		

ST. MARY'S

MARYLAND

ST. MARY'S

RURAL - GREAT RIVER

1 DAY

LEONARDTOWN

ST. MARY'S HOSPITAL

2

1 DAY

CHARLESTON

CHURCH

ST. MARY'S

ALC

NORTH CAROLINA

FARMING

ST. MARY'S HOSPITAL

ST. MARY'S HOSPITAL

ST. MARY'S HOSPITAL

ST. MARY'S HOSPITAL

MARYLAND

ST. MARY'S

LEONARDTOWN

1 DAY

RURAL

ST. MARY'S HOSPITAL, LEONARDTOWN, MARYLAND

NO 1 232

FOR STATE
HEALTH DEPT.

07508

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07500

1. PLACE OF DEATH a. COUNTY St. Marys b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Golden Beach- Mechanicsville c. LENGTH OF STAY IN 1b Patuxent River d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Clinton d. STREET ADDRESS 6407-Pinewood Dr. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First RAYMOND Middle D. Last WEST		4. DATE OF DEATH Month May Day 22 Year 1966	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/5/1946
9. AGE (In years last birthday) 20 yrs.		10. IF UNDER 1 YEAR Months 16 Days 2	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY School	
11. BIRTHPLACE (State or foreign country) Bethesda, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Ray C. West		14. MOTHER'S MAIDEN NAME Joyce E. Rogers	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Ray C. West - same as # 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 9298 Drowning Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH. immediate
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Wading on sand bar + slipped off edge	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 6:30 p.m. 5:22 1966	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Patuxent River	20f. (City or town) (County) (State) Golden Beach St Marys Md
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Wm. D. Boyd EXAMINER'S NAME (Type) Wm. D. Boyd, M.D.		22. DATE SIGNED 5/23/66 M.D. Leonardtown, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF May 25, 1966	23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.	23d. LOCATION (City, town or county) (State) Arlington, Virginia
24. FUNERAL DIRECTOR Robert E. Wilhelm - Suitland, Maryland		25a. REC'D BY REGISTRAR MAY 26 1966	25b. REGISTRAR'S SIGNATURE Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

